

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0035204</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Rosewood Care Center of East Peoria</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2003</u> to <u>6/30/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>900 Centennial Drive</u> <u>East Peoria</u> <u>61611</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Tazewell</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(309) 699-5400</u> Fax # () _____		Paid Preparer (Signed) <u>See Accountant's Compilation Report</u> _____ (Date) _____ (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>																									
IDPA ID Number: <u>431446788001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>4/18/89</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u>																											

SEE ACCOUNTANT'S COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Rosewood Care Center of East Peoria# 0035204 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>7,960</u>	<u>7,960</u>	8
9	SNF/PED					9
10	ICF	<u>13,569</u>	<u>11,324</u>		<u>24,893</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,569</u>	<u>11,324</u>	<u>7,960</u>	<u>32,853</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 74.80%

D. How many bed-hold days during this year were paid by Public Aid?

97 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 4/19/89

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 4/19/89 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 42 and days of care provided 7,960Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/2004 Fiscal Year: 6/30/2004

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	189,455	17,125	8,308	214,888		214,888		214,888			1
2	Food Purchase		163,224		163,224		163,224	(10,572)	152,652			2
3	Housekeeping	125,875	29,248		155,123		155,123		155,123			3
4	Laundry	40,443	16,285		56,728		56,728		56,728			4
5	Heat and Other Utilities			99,569	99,569		99,569	11	99,580			5
6	Maintenance	20,107	16,432	71,770	108,309		108,309	10,744	119,053			6
7	Other (specify):* Sanitation			8,894	8,894		8,894		8,894			7
8	TOTAL General Services	375,880	242,314	188,541	806,735		806,735	183	806,918			8
	B. Health Care and Programs											
9	Medical Director			19,650	19,650		19,650		19,650			9
10	Nursing and Medical Records	1,841,039	164,284	762	2,006,085		2,006,085		2,006,085			10
10a	Therapy	72,466	8,187	454,781	535,434		535,434	(17,213)	518,221			10a
11	Activities	41,763	3,243	2,400	47,406		47,406		47,406			11
12	Social Services	51,113		2,400	53,513		53,513		53,513			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,006,381	175,714	479,993	2,662,088		2,662,088	(17,213)	2,644,875			16
	C. General Administration											
17	Administrative			347,900	347,900		347,900	(215,888)	132,012			17
18	Directors Fees											18
19	Professional Services			3,971	3,971		3,971	30,925	34,896			19
20	Dues, Fees, Subscriptions & Promotions			24,056	24,056	2,200	26,256	(6,977)	19,279			20
21	Clerical & General Office Expenses	145,967	33,557	14,543	194,067		194,067	157,001	351,068			21
22	Employee Benefits & Payroll Taxes			295,926	295,926		295,926	27,690	323,616			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,213	3,213	(2,200)	1,013		1,013			24
25	Other Admin. Staff Transportation			7,749	7,749		7,749	12,441	20,190			25
26	Insurance-Prop.Liab.Malpractice			57,275	57,275		57,275	9,050	66,325			26
27	Other (specify):*											27
28	TOTAL General Administration	145,967	33,557	754,633	934,157		934,157	14,242	948,399			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,528,228	451,585	1,423,167	4,402,980		4,402,980	(2,788)	4,400,192			29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Rosewood Care Center of East Peoria #0035204 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			13,081	13,081		13,081	159,397	172,478			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							525,914	525,914			32
33	Real Estate Taxes			65,360	65,360		65,360		65,360			33
34	Rent-Facility & Grounds			961,424	961,424		961,424	(949,965)	11,459			34
35	Rent-Equipment & Vehicles			27,050	27,050		27,050		27,050			35
36	Other (specify):* Mortgage Insur.							155,934	155,934			36
37	TOTAL Ownership			1,066,915	1,066,915		1,066,915	(108,720)	958,195			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		226,505	17,365	243,870		243,870		243,870			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		226,505	83,245	309,750		309,750		309,750			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,528,228	678,090	2,573,327	5,779,645		5,779,645	(111,508)	5,668,137			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rosewood Care Center of East Peoria**

0035204

Report Period Beginning: 7/1/2003

Ending: 6/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,293)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,213)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(279)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,971)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,338)	20		28
29	Other-Attach Schedule Marketing Salary	(67,715)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (90,809)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(20,699)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (20,699)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (111,508)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center of East Peoria

ID# 0035204

Report Period Beginning: 7/1/2003

Ending: 6/30/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing Salary	\$ (67,715)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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28				28
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30				30
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32				32
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(67,715)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of East Peoria

0035204

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,572)	0	0	0	0	0	0	0	0	0	0	(10,572)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	11	0	0	0	0	0	0	0	0	11	5
6	Maintenance	0	0	10,744	0	0	0	0	0	0	0	0	10,744	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,572)	0	10,755	0	0	0	0	0	0	0	0	183	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(17,213)	0	0	0	0	0	0	0	0	0	(17,213)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(17,213)	0	0	0	0	0	0	0	0	0	(17,213)	16
	C. General Administration													
17	Administrative	0	(347,900)	132,012	0	0	0	0	0	0	0	0	(215,888)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	30,925	0	0	0	0	0	0	0	0	30,925	19
20	Fees, Subscriptions & Promotions	(8,309)	0	1,332	0	0	0	0	0	0	0	0	(6,977)	20
21	Clerical & General Office Expenses	(67,715)	0	224,716	0	0	0	0	0	0	0	0	157,001	21
22	Employee Benefits & Payroll Taxes	0	0	27,690	0	0	0	0	0	0	0	0	27,690	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	12,441	0	0	0	0	0	0	0	0	12,441	25
26	Insurance-Prop.Liab.Malpractice	0	0	9,050	0	0	0	0	0	0	0	0	9,050	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(76,024)	(347,900)	438,166	0	0	0	0	0	0	0	0	14,242	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(86,596)	(365,113)	448,921	0	0	0	0	0	0	0	0	(2,788)	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fee	\$ 347,900	HSM Management Services, Inc.	100.00%	\$	\$ (347,900)	1
2	V							2
3	V	10a Therapy	454,781	Rosewood Therapy Services, Inc.	0.00%	437,568	(17,213)	3
4	V							4
5	V	34 Rent	961,424	East Peoria Real Estate, Inc.	0.00%		(961,424)	5
6	V	30 Depreciation		East Peoria Real Estate, Inc.	0.00%	142,673	142,673	6
7	V	32 Interest		East Peoria Real Estate, Inc.	0.00%	530,127	530,127	7
8	V	36 Mortgage Insurance		East Peoria Real Estate, Inc.	0.00%	155,934	155,934	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,764,105			\$ 1,266,302	\$ * (497,803)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria# 0035204Report Period Beginning: 7/1/2003Ending: 6/30/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 132,012	\$ 132,012
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	224,716	224,716
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	27,690	27,690
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	12,441	12,441
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	16,724	16,724
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	11,459	11,459
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	30,925	30,925
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	9,050	9,050
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	10,744	10,744
24	V	5 See Schedule VIII		HSM Management Services, Inc.	100.00%	11	11
25	V	20 See Schedule VIII		HSM Management Services, Inc.	100.00%	1,332	1,332
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 477,104	\$ * 477,104

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00%	704,579	2	5.99%	Salary	\$ 44,858	17-8	1
2	Darrell Hoefling	Vice President	Management	25.00%	416,519	2	5.99%	Salary	26,519	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 71,377		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 Report Period Beginning: 7/1/2003 Ending: 7/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HSM Management Services, Inc.
 Street Address 11701 Borman Drive, Suite 315
 City / State / Zip Code St. Louis, MO 63146
 Phone Number (314) 994-9070
 Fax Number (314) 994-9912

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 Salaries - Officers	Total Cost	82,623,207	18	\$ 1,192,475	\$ 1,192,475	4,945,500	\$ 71,377	1
2	21 Salaries - Others	Total Cost	82,623,207	18	3,339,865	3,339,865	4,945,500	199,911	2
3	22 Payroll Taxes	Total Cost	82,623,207	18	299,623		4,945,500	17,934	3
4	22 Employee Benefits	Total Cost	82,623,207	18	84,374		4,945,500	5,050	4
5	25 Travel	Total Cost	82,623,207	18	207,846		4,945,500	12,441	5
6	30 Depreciation	Total Cost	82,623,207	18	279,401		4,945,500	16,724	6
7	34 Building Rent	Total Cost	82,623,207	18	191,446		4,945,500	11,459	7
8	19 Professional Services	Total Cost	82,623,207	18	516,651		4,945,500	30,925	8
9	21 Telephone	Total Cost	82,623,207	18	181,396		4,945,500	10,858	9
10	26 Insurance	Total Cost	82,623,207	18	151,190		4,945,500	9,050	10
11	21 Taxes, Licenses & Office Sup	Total Cost	82,623,207	18	233,014		4,945,500	13,947	11
12	6 Maintenance	Total Cost	82,623,207	18	161,460		4,945,500	9,664	12
13	5 Heat & Other Utilities	Total Cost	82,623,207	18	178		4,945,500	11	13
14	20 Dues & Subscriptions	Total Cost	82,623,207	18	22,253		4,945,500	1,332	14
15	17 Direct - Admin	Direct Cost	1	1	60,635	60,635	1	60,635	15
16	17 Direct - Admin	Direct Cost	16	16	941,316	941,316	0	0	16
17	22 Direct - Payroll Taxes	Direct Cost	1	1	4,706		1	4,706	17
18	22 Direct - Payroll Taxes	Direct Cost	12	12	73,065		0	0	18
19	30 Direct - Depreciation	Direct Cost	1	1	0		1	0	19
20	30 Direct - Depreciation	Direct Cost	1	1	2,040		0	0	20
21	25 Direct - Travel	Direct Cost	1	1	0		1	0	21
22	25 Direct - Travel	Direct Cost	1	1	142		0	0	22
23	6 Direct - Maintenance	Direct Cost	1	1	1,080		1	1,080	23
24	6 Direct - Maintenance	Direct Cost	14	14	21,658		0	0	24
25	TOTALS				\$ 7,965,814	\$ 5,534,291		\$ 477,104	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	Allegiant Bank		X	Refinance Debt	Varies	2/27/03	\$ 10,300,000	\$ 0	2/27/05	LIBOR+2.	\$ 118,446	1							
2	Highland Mortgage Company		X	Refinance Debt	\$53,553.68	10/1/03	10,665,100	10,588,225	11/1/38	4.96%	376,535	2							
3	Less: Interest Income Offset										(4,213)	3							
4	Less: Related Party Interest Income Offset										(44,749)	4							
5	Amortization of Loan Fees										79,895	5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$53,553.68		\$ 20,965,100	\$ 10,588,225				\$ 525,914	9						
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$				\$	14						
15	TOTALS (line 9+line14)						\$ 20,965,100	\$ 10,588,225				\$ 525,914	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 155,934 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

0035204 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Rosewood Care Center of East Peoria COUNTY Tazewell
FACILITY IDPH LICENSE NUMBER 0035204
CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz
TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 39,125

B. General Construction Type:
 Exterior
 Brick
 Frame
 Wood
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☐ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	301,000	1988	\$ 77,830	1
2					2
3	TOTALS	301,000		\$ 77,830	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria

0035204

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1989	\$ 2,953,579	\$	10-25	\$ 122,217	\$ 122,217	\$ 2,019,153	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements - Original Construction			1989	209,624		15-25	9,505	9,505	155,939	9
10	Fence			1990	2,377		25	95	95	1,235	10
11	Concrete Work			1991	5,190		25	208	208	2,704	11
12	Painting			1992	7,694		5			7,694	12
13	Irrigation System			1993	10,175		25	407	407	4,511	13
14	Generator			1989	14,937		10			14,937	14
15	Signs			1989	3,157		10			3,157	15
16	Walk-In Cooler			1989	5,770		20	288	288	4,406	16
17	Sinks			1989	3,744		10			3,744	17
18	Exhaust Hood			1989	4,621		10			4,621	18
19	Fire System			1989	1,271		20	63	63	975	19
20	Carpeting			1989	10,368		10			10,368	20
21	Cubicle Track			1989	6,294		10			6,294	21
22	Door Installation			1991	2,750		10			2,750	22
23	Sprinkler Addition			1992	786		10			786	23
24	Ceramic Sink			1994	2,011		10	201	201	1,943	24
25	Parking Lot Extension			2003	37,489		25	875	875	875	25
26											
27	Leasehold Improvements - Facility:										27
28	Carpeting			1994	3,238		7			3,238	28
29	Painting, Baseboard Stripping, Drapery, Tile, Carpet			1995	37,083		7			37,083	29
30	Painting/Tiling			1996	3,960	86	7	86		3,960	30
31	Wallpaper			1998	3,525	502	7	502		3,146	31
32	Floor Covering/Wallpaper/Plants			1998	18,546	2,651	7	2,651		15,048	32
33	Mini Blinds/Wallcovering			1999	5,486	784	7	784		4,126	33
34	Carpeting			1999	4,375	625	7	625		3,021	34
35	Continued on Additional Page										35
36											

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Computer Cabling	2000	\$ 2,392	\$ 341	7	\$ 341		\$ 1,224		37
38	Computer Receptacles	2001	214	29	7	29		105		38
39	Doors	2001	5,966	853	7	853		2,771		39
40	Parking Lot	2001	11,475	1,640	7	1,640		5,192		40
41	Drapes, Wallcoverings, Head Wallcoverings	2001	27,188	3,884	7	3,884		11,234		41
42	Drapery	2003	1,237	177	7	177		251		42
43	Painting	2003	3,112	444	7	444		591		43
44										44
45										45
46										46
47										47
48										48
49										49
50	Leasehold Improvements - Management Company:									50
51	Office Construction/Improvements	1995	458		5			458		51
52	Office Design	1995	42		5			42		52
53	Office Shelving	1996	98		4			98		53
54	Office Expansion	1996	433		4			433		54
55	Office Expansion	1997	1,158		3			1,158		55
56	Office Expansion	1998	653		3			653		56
57	Office Addition	1999	323		3			323		57
58	Door Locks	1999	161		3			161		58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 3,412,960	\$ 12,016		\$ 145,875	\$ 133,859	\$ 2,340,408		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 164,144	\$ 1,065	\$ 19,435	\$ 18,370	5-10 Yrs	\$ 103,384	71
72	Current Year Purchases	9,690		344	344	5-10 Yrs	344	72
73	Fully Depreciated Assets	448,574					448,574	73
74								74
75	TOTALS	\$ 622,408	\$ 1,065	\$ 19,779	\$ 18,714		\$ 552,302	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	\$ 34,325	\$	\$ 6,824	\$ 6,824	4 Yrs	\$ 13,450	76
77										77
78										78
79										79
80	TOTALS			\$ 34,325	\$	\$ 6,824	\$ 6,824		\$ 13,450	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,147,523	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 13,081	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 172,478	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 159,397	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,906,160	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N/A - ONLY HIRE CERTIFIED AIDES If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-8	hrs	\$	21,944	\$ 239,068	\$	21,944	\$ 239,068	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		1,412	739		1,412	739	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		18,295	197,761	8,187	18,295	205,948	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				197,113		197,113	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, Laboratory, Enterals Other (specify): IV Therapy, X-Ray	39-8				17,365	29,392		46,757	13
14	TOTAL			\$	41,651	\$ 454,933	\$ 234,692	41,651	\$ 689,625	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (126,328)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 72,342)	808,060		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,683		6
7	Other Prepaid Expenses	3,358		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 696,773	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	139,119		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(96,476)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 42,643	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 739,416	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 268,551	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	138,127		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,761		31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,218		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	38,300		35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 523,957	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 523,957	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 215,459	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 739,416	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 210,480	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 210,480	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	118,479	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(113,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 4,979	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 215,459	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,202,134	1
2	Discounts and Allowances for all Levels	(1,997,614)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,204,520	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,799,460	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,799,460	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,782	13
14	Non-Patient Meals	10,293	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 14,075	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,213	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,213	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	5,637	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,637	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,027,905	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	806,735	31
32	Health Care	2,662,088	32
33	General Administration	934,157	33
	B. Capital Expense		
34	Ownership	1,066,915	34
	C. Ancillary Expense		
35	Special Cost Centers	243,870	35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,779,645	40
41	Income before Income Taxes (line 30 minus line 40)**	248,260	41
42	Income Taxes	(129,781)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 118,479	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Rosewood Care Center of East Peoria# 0035204Report Period Beginning: 7/1/2003Ending: 6/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,059	2,167	\$ 66,747	\$ 30.80	1
2	Assistant Director of Nursing	1,168	1,229	29,780	24.23	2
3	Registered Nurses	15,190	15,988	367,577	22.99	3
4	Licensed Practical Nurses	24,558	25,847	489,201	18.93	4
5	Nurse Aides & Orderlies	67,746	71,301	813,283	11.41	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,200	4,420	72,466	16.40	8
9	Activity Director					9
10	Activity Assistants	4,367	4,596	41,763	9.09	10
11	Social Service Workers	4,264	4,488	51,113	11.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,381	21,451	189,455	8.83	15
16	Dishwashers					16
17	Maintenance Workers	1,975	2,078	20,107	9.68	17
18	Housekeepers	15,368	16,174	125,875	7.78	18
19	Laundry	5,384	5,666	40,443	7.14	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,261	12,904	145,967	11.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,368	5,650	74,451	13.18	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	184,289	193,959	\$ 2,528,228 *	\$ 13.03	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	360	\$ 8,309	1-3	35
36	Medical Director	Contract	19,650	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	135	2,400	11-3	44
45	Social Service Consultant	135	2,400	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	630	\$ 32,759		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	11	\$ 312	10-3	50
51	Licensed Practical Nurses	13	450	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	24	\$ 762		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria

0035204

Report Period Beginning: 7/1/2003

Ending: 6/30/2004

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rosewood Care Center of East Peoria**

STATE OF ILLINOIS

0035204

Report Period Beginning: **7/1/2003**

Page 23

Ending: **6/30/2004**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association - \$6,480
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 50,522 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,880
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,293
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

ROSEWOOD CARE CENTER INC. OF EAST PEORIA
IDPH ID #0035204
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2004

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	\$ 7,749
	<hr/>
	<u>\$ 7,749</u>

**ALL MILEAGE REIMBURSEMENTS ARE FOR TRAVEL VOUCHERS
SUBMITTED WHICH WERE LESS THAN \$250.00 EACH

IDPH ID #0035204
ATTACHMENT TO SCHEDULE VII, SECTION A.
6/30/2004

RELATED NURSING HOME:

CITY:

ROSEWOOD CARE CENTER OF ALTON	ALTON, IL
ROSEWOOD CARE CENTER OF EDWARDSVILLE	EDWARDSVILLE, IL
ROSEWOOD CARE CENTER OF ELGIN	ELGIN, IL
ROSEWOOD CARE CENTER OF GALESBURG	GALESBURG, IL
ROSEWOOD CARE CENTER OF INVERNESS	INVERNESS, IL
ROSEWOOD CARE CENTER OF JOLIET	JOLIET, IL
ROSEWOOD CARE CENTER OF MOLINE	MOLINE, IL
ROSEWOOD CARE CENTER OF NORTHBROOK	NORTHBROOK, IL
ROSEWOOD CARE CENTER OF PEORIA	PEORIA, IL
ROSEWOOD CARE CENTER OF ROCKFORD	ROCKFORD, IL
ROSEWOOD CARE CENTER OF ST. CHARLES	ST. CHARLES, IL
ROSEWOOD CARE CENTER OF ST. LOUIS	ST. LOUIS, MO
ROSEWOOD CARE CENTER OF SWANSEA	SWANSEA, IL

OTHER RELATED BUSINESS ENTITIES:

TYPE OF BUSINESS:

HSM MANAGEMENT SERVICES, INC.	MANAGEMENT CO.
EAST PEORIA REAL ESTATE, INC.	REAL ESTATE LSG.
HSM DEVELOPMENT, INC.	DEVELOPMENT CO.
RCC HOLDING COMPANY	HOLDING COMPANY
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY